WOMEN'S REPRODUCTIVE HEALTH SITUATION IN EASTERN-TERAI NEPAL

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WOREC (2005) WOMEN'S REPRODUCTIVE HEALTH SITUATION IN EASTERN-TERAI, NEPAL

BY

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ACRONYMS

CBO	Community-Based Organization
CBS	Central Bureau of Statistics
DDC	District Development Committee
FHD	Family Health Division
FHI	Family Health International
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
ICPD	International Conference on Population and Development
IEC	Information, Education & Communication
INGO	International Non-Governmental Organization
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHEICC	National Health Education, Information and Communication Center
NMSS	Nepal Micrometry Status Survey
PHC	Primary Health Center
RH	Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNFPA	United Nations Populations Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organization
WOREC	Women's Rehabilitation Centre

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PREFACE

In most of the rural areas in Nepal, people have a very little knowledge about the causes and preventive measures of various health and nutritional problems. In the national health policy and programme, women's health issues remain inappropriately addressed. In Nepal, women have been facing a number of health problems owing to social discrimination and religious-cultural traditions. These facts suggest that health-related information, education and services are not within the reach of the most people. It is imperative to provide primary health care facilities to them irrespective of their gender status, and make them aware of the fact that health is their basic right.

Women's health has so far been a neglected issue in Nepal. Quite often, it is confused with the family planning and maternal/child health care. Women's health is a much broader concept, which covers various factors and their impacts on social, economic, physical, mental and psychological aspects of women's health. The women's health concern starts with her birth and continues till death. The women's health concept is based on four ethical principles, viz. bodily integrity, womanhood or right to self-determination, equality and respect to diversity among women. An analysis of current health programmes and policies in Nepal revealed that appropriate and adequate importance has not been given to women's reproductive health concerns. It was in this background that WOREC has designed and implemented women's health programme in selected districts. This programme consists of such activities as research, training, education, advocacy, counseling, networking and service.

This report is an output of a research work conducted by WOREC in 2004. This endeavor was made to gather and analyze the first hand information from the grassroots women about their perceptions, socio-cultural and religious traditions, problems and practices in relation to various diseases and/or environment, which are responsible for their subordinate status in the society. This report provides information about the socio-demographic characteristics and the qualitative as well as quantitative information about the traditions, perceptions, problems and practices concerning menstruation, pregnancy and abortion, family planning, nutrition, various gynecological problems and health seeking behaviour of women in eastern Nepal.

I hope that this report will be useful for the health workers, social workers, students and wide circle of population groups both in Nepal and abroad.

I would like to express my sincere thanks to all women who shared their perceptions, understanding and experiences in regard to their health problems and concerns. I would also like to extend thanks to the research team, particularly Mr. Min B. Basnet, for accomplishing this important work.

Dr Renu Rajbhandari
Chairperson

ACKNOWLEDGMENTS

Primarily, we are grateful to the respondents of Morang, Sunsari and Siraha districts for sharing their health problems, perspectives towards their health, and health seeking behavior and practices. Without their time and cooperation, this study wouldn't have been completed.

On Behalf of research team, I would like to owe gratude to Dr Renu Rajbhandari for her valuable advice and professional inputs throughout the research period. We would like to thank Dr Binayak Prasad Rajbhandari who provided us his valuable time in editing the report and for his precious information and full cooperation. We are also thankful to Mr. Baburam Gautam, Secretary of WOREC for his encouragement and support in all aspects of work. In addition, we want to thank Ms. Parbati Basnet, Executive Director of WOREC and all the WOREC's team of Morang, Sunsari and Siraha for this support and cooperation while conducting this study.

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Min B. Basnet

WOREC
Balkumari, Lalitpur, Nepal
February 2006

I. INTRODUCTION

1.1 Background

Nepal is a country inhabited by Hindus, Buddhist, Islam and Christian displaying its religious, ethnic and cultural diversity. Nepalese population worships its cultural norms and values, accepting the artificial rule of subordination of women as the rule of life. The patriarchal rules violate women's rights and promote their commodification, denying control over their own body and thrusting them to take reproductive decision against their will. This is one of the factors responsible for bereavement of women in Nepal.

The Constitution of Nepal ensures equality among all citizens; however in the presence of discriminatory law against women it can never be guaranteed. Despite being a signatory to several UN conventions the advancement of law is slow paced; the law was and still is, bigotry towards its female citizen. The economic, sexual and political exploitation faced by women has always been ignored. As a result, in a country where the health system is already poor, the level of women's health and education is particularly low. The capricious government is financially strained, and is equipped to provide only 15 percent of the Nepali population with such service.

Reproductive and maternal health is of particular concern among Nepali women. In rural Nepal, women are viewed as a machine to bear children, son in particular. Due to lack of awareness and illiteracy most of the women are accompanied by early and excessive childbearing undermining their health; many of them die or are chronically disabled from complications of pregnancy. It is not uncommon for Nepali women to experience a prolapsed uterus after

pregnancy, the main reason for which is strenuous workload without any relaxation. Often, the prolapse is untreated, as it is the physical fault seen in most of the women; and they consider it as natural. In fact, the Human Development Report (1996) has estimated that trained personnel attend only 6 percent of births.

With the advert of the International Conference on Population and Development (ICPD) in Cairo (1994), reproductive health (RH) and women's health in general was looked at in a more holistic way. The ICPD placed reproductive health high on the agenda of national governments, donor organizations and INGOs / NGOs. Its most significant achievement was the shift in orientation from fertility reduction and population policies to reproductive health and factors associated to it. There was also emphasis on reproductive rights, women's empowerment, gender and equity. These principles were outlined in the Cairo Programme of Action, to which Nepal is a signatory. The concept of the reproductive health as a central component of women's development was further endorsed by the Fourth World Congress on Women held in Beijing in 1995.

According to WHO, reproductive ill health accounts for 33 percent of the total disease burden in women as compared to 12.3 percent for males. Despite this significant figure, in many South-Asian countries the magnitude of reproductive morbidity has not been adequately defined (WHO 1995). The report further states that osteoporosis, uterine prolapse and other gynecological complications contribute significantly to reproductive morbidity; and has stressed the need for systematic collection of data and information on these illnesses.

The situation of women's reproductive health in Nepal is reported to be rather gloomy. It is now being increasingly realized that many of our development programmes fail to recognize and address problems

from women's perspective. An analysis of existing health programmes in Nepal has revealed that inadequate importance has been given to women's reproductive health concerns.

WOREC has been advocating that woman's health concern begins from her birth and continues till death. The question is, are these rights in practice in Nepal, where woman is viewed as a mere biological means of reproduction. Various discriminatory factors have been influencing the women's health and relevant attitudes. These factors have always been disregarded. Research works on women's health aspects in Nepal have been scanty. In the absence of adequate research, effective strategic intervention planning is simply impossible. Keeping this view in mind, this study was conducted in three Eastern districts of Nepal in order to complement the previous study conducted by WOREC in Western districts in 1998.

Participants of Women's Health Training

1.2 Reproductive health and research

In Nepal, the social sciences have made limited contributions when it comes to research in community health; and relatively few of these efforts have addressed the needs of applied health programmes (Koirala 2003). Qualitative researches, particularly "rapid" anthropological methodologies, are especially appropriate for describing the system of factors that influence women's health. These methods are ideal for exploratory research, for hypothesis generation, and for programme planning, monitoring, and evaluation. To incorporate the social sciences appropriately into applied work in women's health requires a strategy that balances a strong focus on useful short-term applications with selective strengthening of institutional capacity.

Women's reproductive health remains largely unexplored in Nepal. Meticulous study is required to identify women's health problems in Nepal and to identify the factors behind its occurrence. Along with clinical and epidemiological data on women's reproductive health, descriptive ethnographic studies are required to find out how women perceive their own health and how these factors influence their decisions to utilize health care services.

1.3 Policy review

The safe abortion policy 2002 was developed in the context of 11th Amendment of the Muluki Ain 2020 B.S. (The law of the land 1959), the basic Code for the kingdom of Nepal. This amendment reformed the restrictive abortion framework, which prohibited abortion, and characterized it as an offence against life. His Majesty's Government (HMG) of Nepal amended the Nepal Abortion Bill in March 2002; and Royal Assent was given on the Bill on 26th

September 2002. The Eleventh Amendment provides provision for safe abortion upon voluntary consent of the women on the following grounds:

* Within first twelve weeks of pregnancy;
* Pregnancy due to rape or incest within first 18 weeks of pregnancy;
* Or when women's pregnancy poses danger to her life or to her physical and mental health, abortion can be performed with the advice of a medical practitioner at anytime during pregnancy,
* Abortion can also be performed if, in the view of the medical practitioner, the pregnancy would lead to the birth of a disabled child at any time during pregnancy with recommendation of medical practitioner.

Since the late 1960s, His Majesty's Government of Nepal (HMG/N) has recognized the need to balance population growth with economic growth. Its family planning programme supports a variety of approaches, including outreach programmes, community-based programmes, and private sector involvement.

Family Health International (FHI) worked for two decades, in cooperation with USAID, the Ministry of Health, and the Ministry of Population and Environment, to improve family planning in Nepal. FHI helped in developing policy, formulating research protocols, analyzing data and disseminating information. It played a central role in advising senior-level reproductive health policy makers, international donor agencies, and local and international non-governmental organizations (NGOs). These groups use FHI's data, and analyze it to formulate plan and policies. FHI's current activities include studies on the health status of adolescents in Nepal and the efficacy of vasectomy as a method of contraception, and assistance

to the Government's National Planning Commission in preparing the ninth five-year development plan.

Painful menstruation, or dysmenorrhoea, is a common complaint both in the developing and developed countries alike. Harlow and Campbell (2000) have summarized a series of studies and suggested that dysmenorrhoea is present in 28-57 percent of Indian women, 56 percent of Turkish women and 25-58 percent of women in other WHO study. Likewise, irregular bleeding, which suffers from an inadequate definition, was reported in 8-83 percent of the women in the WHO study, 30 percent of Vietnamese factory workers, 5-9 percent of Indian women, 6 percent of Lebanese healthcare seeking women, and 13 percent of Turkish women. Harlow and Campbell (2000) also review the prevalence of abnormal uterine bleeding, mostly excessive bleeding. Bang *et al* (1998) found that menstrual disorder represented a large portion of reproductive morbidity in India in their classic study; likewise, Bhatia *et al* (1999) reported 15.4 percent of women complained of menstrual problems (Bonetti, *et al* 2002).

1.4 Reproductive health problems

Abortion statistics are disreputably incomplete, where induced abortion is restricted or illegal; its occurrence can be estimated only indirectly. As there are no feasible data collection methods that can reliably reflect the overall burden of unsafe abortion, one is left to work with incomplete information on incidence and mortality from community studies or hospitals. This is then adjusted to correct for misreporting and under-reporting, using information on abortion laws and their application, providers of unsafe abortion, common methods of unsafe abortion and other pertinent information. The

adjustments depend largely on the methods commonly used to perform the abortion, and assumptions about the relative incidence of unsafe abortion in rural and urban areas.

1.5 Social and cultural issues

Several studies argue the second-class citizenry of Nepali women (Bonetti *et al* 2003; Christian *et al* 1998; Reynolds et al 1988; Christian and West et al 1998; Gittelsohn *et al* 1997; Messer 1997). Additionally, girls are often viewed as a burden of families - they will cost the family in dowry and also leave the family to live with their husband's family. Even though women do almost all of the household chores, such work is not viewed as productive work.

Christian *et al* (1998) found several socio-economic factors that influenced Nepali women's decisions of seeking treatment for the illness. Family, neighbors and friends' opinions about the disease impacted women's treatment decisions. Additionally, willingness of husbands to assist their wives, lack of personal access to money contributes to a woman's decision regarding her illness. In the 'Three-Delays Model' for accessing obstetric emergency care, the initial delay is the decision to seek care - a decision most often controlled by the husband or mother-in-law and one based on the women's perceived value.

Gittelsohn et al (1997) found that the social and cultural status of individuals is governed by age, gender and kin relationship, and pointed out the difficulty of early adult years for Nepali women:

"A woman marries and moves into her husband's household, where she has a very low status. She is expected to do a great amount of the

hard physical work, produce children and not complain about her state; junior adult females receive subtle discouragement in the consumption of special foods."

Bonetti (2000) noted that women fail to seek treatment for pelvic organ prolapse because of financial and cultural restraints. Deeper analysis of the constraints revealed a core sense of helplessness driven into the women's sense of identity through generation of repression. Women also maintained a cloak of silence due to the dirty and shameful social stigma associated with prolapse. Two additional themes emerging from the research concluded that women felt replaceable primarily because they were valued not as individuals, but rather for their ability to work and bear children (Ibid).

Women Participants of Women's Health Day

1.6 Objectives of the study

Overall objective of this research was to analyze the status of women's reproductive health in rural areas of eastern Nepal.

The specific objectives of this work were as follows:

* Identify the situation of women's health status in rural areas;

* Analyze the traditions and perceptions of women in relation to menstrual problems;

* Assess the traditions, problems and practices in relation to pregnancy and abortion;

* Analyze the perception, traditions, problems and practices regarding family planning in rural areas;

* Find out nutritional status of rural women and relevant health problems;

* Find out common gynecological problems among rural women; and

* Analyze the health service-seeking behavior of women and relevant traditional taboos prevalent in rural areas.

II. RESEARCH METHODOLOGY

This study was carried out during October to December 2004. The study covered three districts of eastern development regionviz. Siraha, Morang and Sunsari. Within these districts, 13 Village development committees (VDCs) were selected as the sample for data collection. In Siraha district Bastipur, Padariya and Govindapur VDCs were covered, while in Morang district Urlabari, Letang, Majhare, Pathari, Jhurkiya, Amardaha and Tukuwa and in Sunsari district Rajgunja, Sinuwari, Purwakusaha were covered by this study. This study was confined to these districts because WOREC has been implementing various programmes in these districts.

2.1 Data collection and analysis

a. Qualitative data collection

Two methods were applied to gather qualitative information.

i. Field observation: To get the reality or real situation of women's health status researchers visited various research fields and collected perception, problems and opinion of rural women.

ii. Secondary data: In order to verify and justify the primary data some secondary data were also used in this research. The secondary data were taken from various sources.

b. Quantitative data collection

Quantitative information was gathered by employing structured questionnaire (Annex -ii) during October to December 2004. A total of 398 women in Siraha and 1221 women in Morang and Sunsari were interviewed. Thus the total number of respondents was 1619. The questionnaire also used in this study was used for the research conducted in other four districts in 1997 (Rajbhandari & Rajbhandari 1998).

c. Data analysis

A total of 1619 questionnaires were obtained from the research areas; and data of the survey were analyzed in the computer employing SPSS soft-ware.

2.2 Limitation of the study

The present study is based on the information gathered from three districts of eastern Terai of Nepal. The findings of the study cannot be generalized for the country as a whole. The information of this study has revealed similar situation of the women in Terai and rural community of eastern Nepal. However, the specific situation could be a little bit different in other parts of Terai region.

III. THE STUDY DISTRICTS

3.1 SIRAHA

Siraha district lies in Sagarmatha Zone. It has total area of 1,188 Sq. Km. The elevation is 76 m to 895 m. There are altogether 106 VDCs and 2 municipalities. The whole district is divided into 5 constituencies. According to the census of 2001 (CBS 2002), there are 572,399 people living in the district. The ratio of male and female was 1:06. There were 100,010 households and the average household size was 5.72. There were 482 people living in one square km and the urban population was 9.06 percent. The literacy rate was 40.3 percent in average with 26.80 percent of female. It was found that the net enrollment ratio of school going age children in primary level was 68.8 percent, lower secondary 29.5 percent and secondary 21.7 percent. The human development index was 0.350, the number was 63,320 and population per hospital bed 2,000. There were 18.97 percent households with access to toilet facilities and 53.43 percent of population with access to safe drinking water (District Development Profile of Nepal 2004).

3.2 MORANG

Morang district lies in Koshi Zone in the eastern development region of Nepal. It has total area of 1855 Sq. Km. The elevation is 140 m to 2409 m. There are altogether 65 VDCs and 1 sub-metropolitan city. The whole district is divided into 7 constituencies. According to the census of 2001, there are 843220 people living in the district. The male and female population is 422895 and 420325, respectively. The

ratio of male and female was 100:61. There were 167875 households and the average household size is 5.02. There were 454.5 people living in one square km and the urban population was 19.78 percent. The literacy rate was 57.0 percent in average with 46.8 percent of female. It was found that the net enrollment ratio of school going age children in primary level was 79.05 percent, lower secondary 59.85 percent and secondary 40.15 percent. The human development index was 0.421, the number of people per doctor was 14054, population per hospital bed 5154. There were 41.6 percent households with access to toilet facilities and 52.96 percent of population with access to safe drinking water. Similarly the number of mobile clinic/PHC is 285, number of women health volunteer is 585, number of family planning method users is 62.94%. ANC first visit of Exp-pregnancy is 79.4 % and PNC first visit of Exp-pregnancy is 32.2%. (Source: www.ddcmorang.org.np)

Map 1. Map of Nepal showing study districts

3.3 SUNSARI

Sunsari district lies in Koshi Zone in the eastern development region of Nepal. It has total area of 1257 Sq. Km. The elevation is 152 m to 914 m. There are altogether 49 VDCs and 3 municipalities. The whole district is divided into 5 constituencies. According to the census of 2001, there are 625633 people living in the district. The male and female population is 315530 and 310103; respectively. There were 120295 households and the average household size is 5.20. There were 498 people living in one square km. The literacy rate was 45 percent in average with 30.3 percent of female. It was found that the net enrollment ratio of school going age children in primary level was 78.65 percent, lower secondary 55.05 percent and secondary 38.15 percent. The human development index was 0.500. *(District Development Profile of Nepal 2004).*

IV. RESULTS AND DISCUSSIONS

4.1. Socio-demographic Characteristics of the Respondents

It is very important to have knowledge about the socio-demographic characteristics of the targeted population groups in order to understand and analyze their health issues properly in a comprehensive manner. This study therefore attempted to gather comprehensive socio-demographic information of the population groups in Siraha, Morang and Sunsari districts. A total of 1619 women participated in structured interviews out of which 398 were from Siraha and 1221 from Morang and Sunsari. Out of the 1619 respondents, 40 (2.47 %) were unmarried adolescent girls and 1579 (97.52 %) were married. Out of 398 respondents in Siraha, 397 were married and 1 was unmarried and out of 1221 respondent in Morang/ Sunsari, 1182 were married and 39 were unmarried The age distribution of the respondents is given in Chart 1.

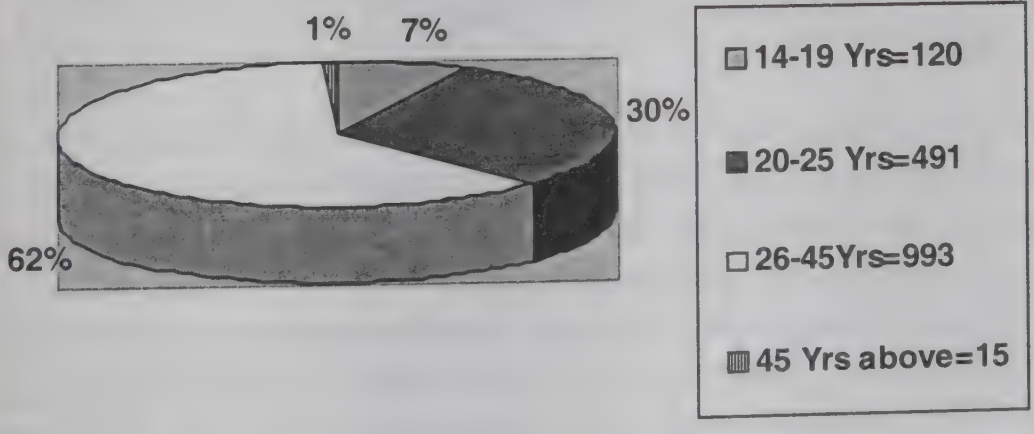

Chart 1. Distribution of respondents by age group

Field Survey: 2004

Chart 1 shows the percentage distribution of the respondents by age group. It is evident that above 90 percent of the respondents belonged to active reproductive age group of 20- 45 years.

5.2. Menstruation

More than two third of the respondents (79%) attained menarche by the age of 12-15 years. It is interesting to note that 2 percent of the respondents reported that their menstruation initiated below the age of 12 year (Table 1).

Table 1. Respondent's age at the initiation of menstruation

S.N.	Age Group	No. of respondents	Percentage
1	Less than 12 years	38	2
2	12 - 15 years	1285	79
3	16 - 20 years	287	18
4	No response	9	1
	Total	**1619**	**100.00**

Field Survey: 2004

In previous studies on reproductive health situation in Nepal, most of the girls were found unaware about the concept of reproduction prior to the onset of menarche; they gradually learnt of the association between menses and reproduction. Owing to the lack of prior knowledge among most of the girls, their first reaction at the onset of menarche was usually negative (Rajbhandari & Rajbhandari 1998). A number of other studies have also indicated that there are misconceptions, ignorance and incomplete knowledge about the biological basis of menstruation among young girls.

Menstrual disorders

In the face of life-threatening problems related to child-bearing and childbirth, the relatively minor problems of menstrual disorders have received little recognition (Garg *et al* 2001; Harlow and Campbell 2000). Several studies do point to the growing interest in menstrual disorders as a determinant of reproductive morbidity, yet few studies delineate the socio-cultural and psychological impact of menstrual disorders on women's lives (Ibid).

Research findings about the menstrual disorder in Eastern Nepal is presented in Table 2.

Table 2. Menstrual disorders

S.N.	Types	Siraha	Morang/ Sunsari	Total	Percentage
1	Regular	325	705	1030	63
2	Irregular	72	505	577	36
3	No response	1	11	12	1
	Total	**398**	**1221**	**1619**	**100.00**

Field Survey: 2004

In this study, 36 percent of the respondents were found having irregular menstruation (Table 2). Menstruation is reported to cause various health problems associated with specific signs and symptoms. The major signs and symptoms identified during menstruation were excessive bleeding, backache, lower abdominal pain, blood clots etc. (Table 3). About one third (33 %) of the respondents reported that they experienced backache during menstruation. More than one fourth (26 %) of the respondents experienced lower abdominal pain during

menstruation and about a quarter reported excessive bleeding (24%) during menstruation. These results were found at par to the findings of previous study (Table 4) conducted by WOREC in Udayapur, Nuwakot, Salyan and Baitadi districts (Rajbhandari & Rajbhandari, 1998).

Table 3. Symptoms encountered during menstruation*

SN	Symptoms	Number	Percentage
1	Excessive bleeding	798	24
2	Backache	1113	33
3	Lower abdominal pain	894	26
4	Blood clots	580	17
	Total	**3385**	**100.00**

*Field Survey: 2004, * multiple response*

The causes of this illness have been attributed to heavy work loads, weakness, consumption of "hot" foods, intercourse during menstruation and side-effects of tubectomy *(Ibid)*.

Table 4. Symptoms encountered during menstruation*

SN	Symptoms	Number	Percentage
1	Excessive bleeding	130	31
2	Backache	188	25
3	Lower abdominal pain	167	22
4	Blood clots	101	14
5	Other	64	8
	Total	**750**	**100.00**

Multiple responses

Source : Rajbhandari & Rajbhandari 1998

In regard to the socio-cultural aspects of menstruation, the rural women of Nepal have been experiencing the dishonor and misbehave. It is well known that in Hindu cultures, and often in Muslim cultures as well, menstruation is considered dirty; and is marked by extensive taboos, particularly in regard to sexual activity, cooking and socializing. Basically, the taboos are strictly practiced in so-called high caste Hindu rather than the ethnic minor groups in Nepal.

5.3 Pregnancy and abortion

In most of the rural areas of Nepal, girls are married in a very young age of 14 to 16 years and often to much older men. In the study area, marriage starts from the age of 12, so, adolescent pregnancy

Women Participants in a Women's Health Mela

possesses grave health risks to the young mother. Relatively high proportion of teenage pregnancies has been reported to end in fetal loss, induced abortion or infant mortality as well as other harmful consequences to the mother. Son preference, reflected in discrimination against female children in allocation of food and

utilization of health services in a household, can be taken as an explanation for excess female mortality in childhood.

Among the respondents 32 percent had experienced miscarriage and/or abortion (Table 5). Out of these respondents, 20 and 22 percent had miscarriage of 1-3 month and 3-6 months fetus, repectively, while 11 percent of these respondents had miscarriage of above 6 months fetus (Table 5).

Experience of the respondents revealed that excęssive workload, poor nutritional security coupled with gender-based discriminatory values and practices are the grave risks for younger mother, fetus and babies. Abortion or miscarriage is reported to be extremely dangerous from the perspective of health and social consequences.

Table 5. Frequency of respondents by month of miscarries/ abortion

SN	Month of abortion	Number	Percentage
1	**No miscarriage / abortion**	**1101**	**68**
2	**Miscarriage/abortion/ dead birth**	**518**	**32**
a.	1-3 months/fetus	104	20
b.	3-6 months/fetus	115	22
c.	Above 6 months/fetus	58	11
d.	Died after birth	241	47
	Total	**1619**	**100**

Field Survey: 2004

The religious-cultural tradition prevalent in Nepal can also be considered partially responsible for the reproductive health problems of women. Early marriage and pregnancy cause various health problems to women. Reasons given for families preferring son to daughters include that sons maintain and extend the lineage, inherit property, provide support to parents in old age and farm the family land. In the other hand, daughters are regarded as a liability because they marry early and have to leave the family. The first reference to abortion occurs in the Atharva Veda (2000-800 BC). The Birhadyogalarianingin (1st century BC) is said to contain several contraceptive recipes, including a method for the occlusion of the cervix (Chandrasekar 1974). Three Sanskrit medical classics written respectively by Susruta, Charaka and Vaghbata I, which comprise the main body of knowledge of ancient Hindu medicine, deal with abortion and miscarriage amongst other reproductive issues (Ibid). Susruta differentiates between "garbhapata" (spontaneous abortion) and "garabhasrava" (induced abortion). The former is classified as that which is up to four months, when only liquid is said to flow from the womb; the latter, when the limbs of the foetus have gained firmness or it is visible (Ibid). Abortion on a fairly large scale is stated to have existed during the Gupta period, the golden age of the Hindu history. Even then, there were prescribed periods of gestation beyond which abortion was prohibited. The fetus had to be aborted before it gained firm shape or viability (Manekar 1973). However, abortion has now been legalized in Nepal.

Abortion or miscarriage has been reported to be extremely dangerous from the perspective of health and social consequences. In the study area, miscarriage and abortion has been doomed to suspicions of wrong doing or/and witchcraft. The women suffering from miscarriage are not provided with proper care and nutritional food, even the needed rest. Despite this, the safe abortion policy 2002

was developed in the context of 11th Amendment of the Mulki Ain 2020 B.C. (Muluki Ain/HMG, 1959), the basic code of the Kingdom of Nepal. This amendment has reformed the restrictive abortion framework, which had prohibited abortion characterizing it as an offence against life.

His Majesty's Government of Nepal amended the Nepal Abortion Bill in March 2002 with some terms of condition. Even though, most of the rural women have been suffering and victimized from unsafe abortion practices. Out of 518 respondents 74 women had miscarriage at their will and 183 (35%) respondents had unwanted abortion (Chart 2). These were due to the unsafe sex and early-marriage. The most common abortion complications were incomplete abortion, sepsis, hemorrhage, and intra-abdominal injury. Except for intra-abdominal injury, all complications resulted from either spontaneous abortion (miscarriage) or induced abortion. Left untreated, each can lead to death. Also, women surviving immediate abortion complications often suffer life-long disability or face elevated risk of complications in future pregnancies.

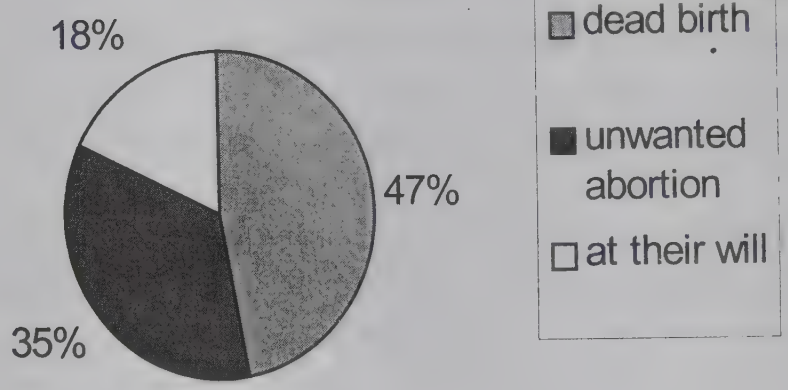

Chart 2. Frequency of respondents by the type of miscarriage/abortion

In this study, most of the respondents (63 percent of the women who had experienced abortion/miscarriage), had it in the village/house while only 29 percent of them had induced abortion in some health institutions (Table 6). And in another question, 86 percent of these women reported that they fell sick after abortion. When tissue remains in the uterus either after miscarriage or unsafely induced abortion, the woman suffers "incomplete abortion," which is most common abortion complication in rural areas. Typical systems included pelvic pain, cramps or backache, persistent bleeding, and a soft, enlarged uterus. Such types of reproductive health problems were usually found in the study area. It should be noted that in this study, out of 518 respondents experiencing miscarriage/abortion only 166 (32%) women had visited doctor after miscarriage and rest (68%) ignored it (Chart 3).

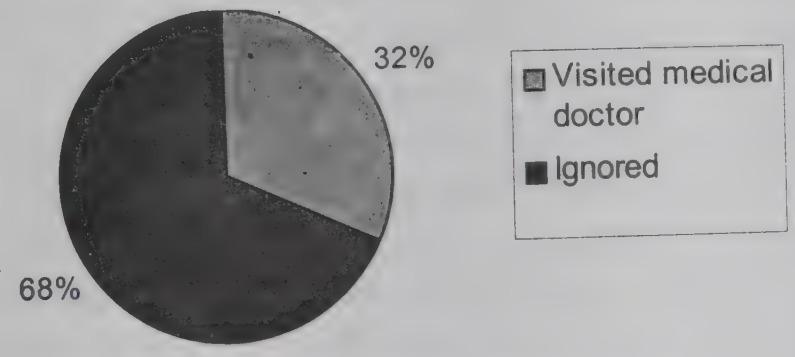

Chart 3. Health service seeking after miscarriage

Table 6. Place and ways of miscarriage/abortion occurred

SN	Place	Number	Percentage
1.	In the village /home	328	63
2.	In the health institution/hospital	149	29
3	By taking medicine with out prescription	34	7
4	Putting some thing inside	7	1
	Total	**518**	**100**

Field Survey: 2004

In Nepal, unsafe abortion is entirely preventable. Yet, it remains a significant cause of maternal morbidity and mortality in much of the rural Nepal. Almost all of the abortion and miscarriage occurs unsafe in the rural community. Women who resort to unskilled or untrained abortion providers put their health and life at risk. Worldwide an estimated 68,000 women die as a consequence of unsafe abortion. In developing countries, the risk of death is estimated at 1 in 270 unsafe abortion procedures. Where contraception is inaccessible or of poor quality, many women seek to terminate unintended pregnancies, despite restrictive laws and lack of adequate abortion services. Prevention of unplanned pregnancies by improving access to quality family planning services must therefore be the highest priority, followed by improving the quality of abortion services, with legal and post-abortion care.

4.4 Family planning

In 1993, a review of family planning and reproductive health IEC in Nepal was conducted by JHU/ PCS on behalf of the MOH Nepal and USAID (Rimon & Lediard 1993). That review revealed a decline in IEC activities since the early 1980s owing to erosion of human resource and morale associated with a series of political changes in the government. Most importantly, the review suggested that the IEC sector, which had historically played a peripheral role, needed to be integrated into the MOH as a key component of scientifically sound health and family planning promotion efforts aimed at addressing unmet needs. The "Redline Strategy," which refers to breaking through the barriers of unmet need was developed from that review process. In 1993, the MOH created the National Health Education, Information, and Communication Center (NHEICC) within its Family Health Division (FHD) to coordinate health communication activities.

Following the long-term Health Plan (1997-2017), the national reproductive health strategy of Nepal, formulated in 1998, emphasized the prevention and management of STI/HIV/AIDS and other reproductive health issues through an integrated reproductive health package introduced at hospitals, primary health centers (PHC), health posts, sub-health posts, outreach clinics, TBAs and FCHVs. The national reproductive health strategy is relatively progressive compared to the long-term national health plan in addressing the STI/ HIV/AIDS epidemic in Nepal. However, the strategy does not clearly spell out the intervention approach and programmes required fighting the high risks and safeguarding the vulnerable groups of people.

In this study, 638 respondents had reported that they used means of family planning in their life time, rest of the respondent do not have experience about the contraceptives. Among the contraceptives users 194 had side effects of contraceptives (Chart 4).Responding to a query about availibility of contraceptives, 49 percent of the respondents reported that they can easily get contraceptives in their locality (Chart 5).

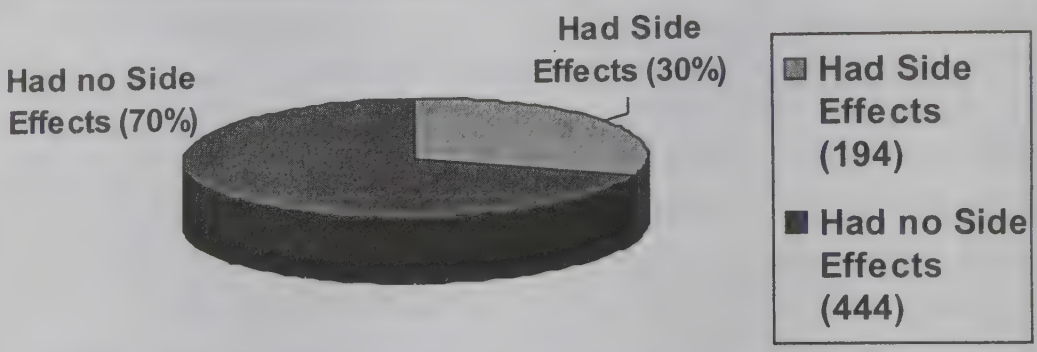

Chart 4. Response about the side effects of contraceptives

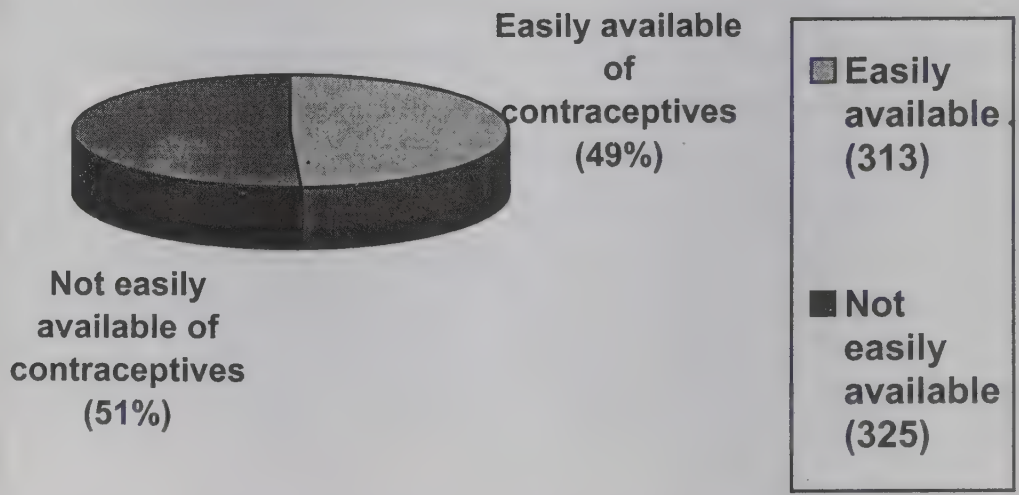

Chart 5. Availability of FP contraceptives

4.5 Nutrition / Health

In Nepal, nutrition is very much related to and determined by socio-cultural factors. Current nutrition data hold that adequate energy intake does not necessarily assure a diet that has adequate micronutrient intake (Gittelsohn *et al* 1997; NMSS 1998). The situation of food security in studied community is poor (Ibid). Malnutrition has been one of the major factors causing women's reproductive health problems. Weakness is the major complaint of rural women. It has been identified involving either protein malnutrition or specific deficiencies such as iron (deficiency anemia). The severe and chronic iron (deficiency anemia) has been found to elevate the risk of miscarriage, prematurity, parental morbidity and even death.

Various ethno-cultural and traditional beliefs prohibiting consumption of iron-rich food to the pregnant and child-bearing women have been found responsible for these health problems of women. The nutritional deprivation of young/adult women affects not only their own health but also the health of the fetus and nursing child. Women were forced to do excessive labour together with anemia which was reported to be one of the causes of maternal death and/or miscarriage (Rajbhandari & Rajbhandari 1998).

In the multiple response, different reproductive health-related problems were found in the study area. Various signs and symptoms of anemia as perceived by the respondents are as presented in the Chart 6. Frequency of these signs and symptoms, which were reported by more than 50 percent of the respondents, included shortness of breath and tongue, nail and eye became whitish and had no good sleep.

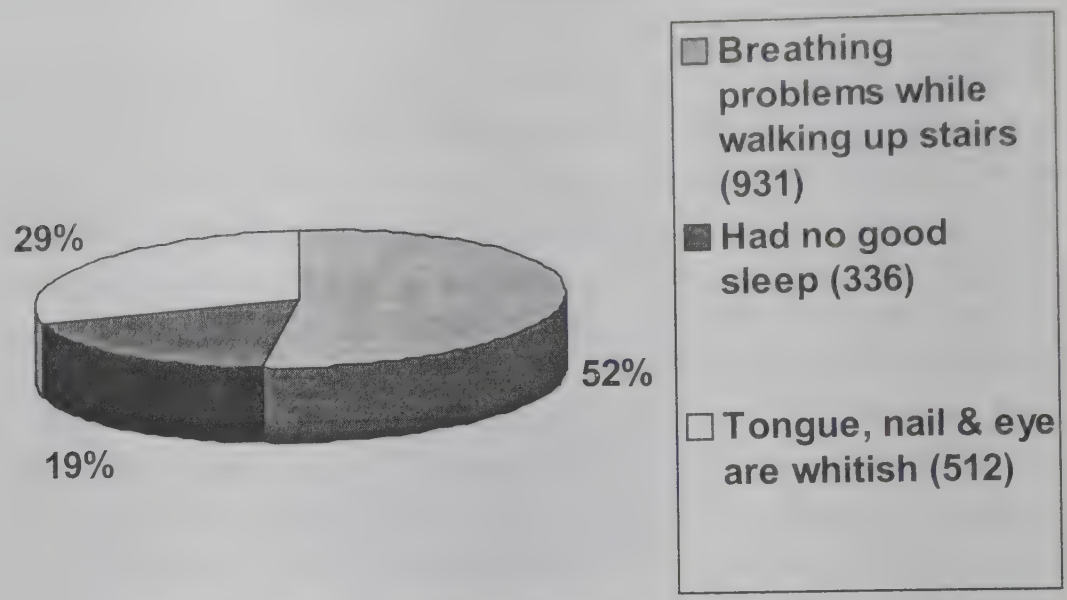

Chart 6. Frequency of signs and symptoms

4.6 Gynecological problems

Uterus Prolapse

Women's reproductive health remains largely unexplored in Nepal. Epidemiological studies are needed: to identify the most serious women's health problems in Nepal; to determine their relative prevalence; and to identify the factors of these problems. Along with clinical and epidemiological data on women's reproductive health, descriptive ethnographic studies are needed to establish how women perceive their own health and morbidity; how these factors influence their decisions to utilize health care services; and how they use them. At present, there is a dearth of anthropological data on women's health available to guide programme decisions and resources.

IIIrd degree prolasped uterus

In this study, 265 respondents reported that they had difficulty to sit comfortably due to prolasped uterus. Uterus prolapse is commonly called as "aang khasne" in Nepali. Out of the total respondents (351) 345 had prolapsed uterus of which 21 percent reported having 2nd degree prolapsed and 5 percent with 3rd degree prolapsed uterus (Table 7).

Duration of uterus prolapsed ranged from less than one year (16%) to more than two years (36%). It should be noted that 28 percent of the women suffering from prolapsed uterus did not provide the duration of their suffering (Table 8). This fact indicates that they did not want to share their sorrows with the enumerators.

Table 7. Uterus prolapsed

SN	Stage of prolapse	Number	Percent
1	A little (1st)	254	74
2.	More (2nd)	75	21
3.	Whole (3rd)	16	5
	Total	**345**	**100**

Field Survey: 2004

Table 8. Duration of uterus prolapsed

S.N	Duration of uterus prolapsed	Frequency	Percent
1.	missing value	97	28
2.	less than one year	58	16
3.	1- 2 year	65	18
4.	more than two year	125	36
	Total	**345**	**100**

Field Survey: 2004

Table 9. Attempts to stop the prolapsed uterus

SN	Attempts to stop the prolapsed uterus	Number	Percent
1	Put ball inside the vagina	17	4
2.	Medicine	57	16
3.	Checkup by doctor	15	4
4.	Did nothing	196	56
5.	Missing value	60	17
	Total	**345**	**100**

Field Survey: 2004

Table 9 shows that 56 percent of the respondents did not attempt for any treatment while they had uterus prolapse and few of them had put ball. It is very dangerous to vaginal infection. Women in the study area had diverse opinions concerning prolapse. Girl under 18 years generally did not know about prolapse; and the women did not inform anyone about their problem and lived with the problem for many years. There were reports of women facing the problem for more than 20 years. They shared their problems with husbands or female members of the family, but could not have proper treatment.

Women with prolapsed uterus reported discomfort, foul smell, vaginal discharge, uncomfortable urine discharge and pain during sexual intercourse as their problems. Other problems included vaginal bleeding, backache, weakness, increase in frequency of urination, involuntary urination during coughing, discomfort feeling of uterus coming out while coughing and burning sensation or a kind of discomfort during urination.

4.7 Health service seeking behavior

This chapter presents the health care seeking behavior, practices and decision-making concerning women in the study areas. Non-pregnancy and pregnancy-related issues are raised in the structured questionnaire. Irrespective of age and ethnicity women reported that they did not report their reproductive health problems to anyone but suffered in silence. They were found too hesitant to discuss and share their problems to anyone. It is affected by many factors such as availability, distance, costs, quality of care, social structure and health beliefs. Many of these factors were found interrelated and/or integrated with gender inequality reflected in women's subordinate

status in the society. In western parts of the country also similar behaviour was reported *(Rajbhandari & Rajbhandari 1998)*.

On the other hand, there were women who consulted with the traditional faith healers and used herbal medicines. The women were taken to a health care facility like the health post, health center or hospital for medical attention only when the problem became serious. It was not until the problem became unbearable that women shared their problems with other members of the family. In general, we could find that girls less than 18 years share their problems with their mothers or close friends while others discussed it with female relatives and colleague. Husbands were also consulted but many women responded that husbands do not respond so they tend to discuss problems with others who they think could help them. When husbands were out of home or village, women had no choice but to consult other members of the family and friends.

V. CONCLUSIONS AND RECOMMENDATIONS

The ultimate aim of this study is to analyze the situation of women's reproductive health as well as women's health related issues. This research was carried out to reflect the prevalence of women's reproductive health problems in the eastern terai of Nepal. This study covered the three districts: Morang, Sunsari and Siraha, which are working areas of WOREC. Various reproductive health problems found in this research are embedded with socio-cultural perceptions and practices against the women. In order to improve the health status of women, efforts should be made to change such discriminatory socio-cultural, socio-religious and patriarchal structure of Nepalese society. Women in the study, irrespective of age and ethnic groups perceived reproductive health issues as very private and personal. As a result, issues related to reproductive health were not openly discussed with anyone until they got affected seriously.

5.1 CONCLUSIONS

Based on the findings of this research the following conclusions have been made:

* Thirty six percent of the respondents had irregular menstruation. In the course of group discussions, respondents suggested that each sub-health post should have basic reproductive health facilities and care unit.

* This research demonstrates that sixty three percent of the miscarriage/abortion had occurred in the village or/and home. Community awareness campaign and integrated reproductive health services are recommended to minimize the risk of miscarriage.

* More than fifty percent of the respondents complained of having breathing problems while walking up stairs and 512 had found the anemic symptoms. To address these types of health problems, community level health care system has to be restructured from women's perspective. Furthermore, change in cultural taboos regarding nutrition to women is a must.

* In this study, 265 respondents had difficulty in sitting comfortably, out of 1619 respondents twenty one percent had prolapsed uterus. Thus, it indicates that work load is high for women, on the other hand health service and women health care service is excessively low grade.

* Understanding of reproductive health among the respondents in study was far from satisfactory. They were in dilemma and did not know how to differentiate between problems and normal discomfort. It shows that knowledge about their body & reproductive health is negligible.

5.2 RECOMMENDATIONS

Analysing the findings of this research and conclusion drawn from the study the following recommendations have been made:

* HMG/N should work out policy to reduce work burden to pregnant women and girl children/ adolescent girls in rural areas.

* HMG/N should make basic health care facilities including family planning contraceptives availability, women health counseling and basic reproductive health care service at grass root level.

* HMG/N should revise its health policy and program from the perspective of human rights of women; and to include women's health programme as an essential component.

* Legal provisions as well as cultural changes are imperative to ensure women's access to proper nutrition and quality health care facility as well as counseling at the grassroot level.

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Mission

Contribute for creating the equitable Nepali society based on social justice and human rights.

Vision

In order to achieve its mission in a sustainable way, WOREC would play the role of an active national NGO engaged in the prevention of trafficking in women and the promotion of women's rights.

Strategy

1. Collective empowerment and social mobilization.
2. Advocacy for social justice, equity, peace and reconciliation.
3. Sustainable resources, management and livelihood.

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